General

Guideline Title

Pressure ulcer prevention. In: Evidence-based geriatric nursing protocols for best practice.

Bibliographic Source(s)

Ayello EA, Sibbald RG. Preventing pressure ulcers and skin tears. In: Boltz M, Capezuti E, Fulmer T, Zwicker D, editor(s). Evidence-based geriatric nursing protocols for best practice. 4th ed. New York (NY): Springer Publishing Company; 2012. p. 298-323.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Ayello EA, Sibbald RG. Preventing pressure ulcers and skin tears. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company; 2008 Jan. p. 403-29.

Recommendations

Major Recommendations

Levels of evidence (I–VI) are defined at the end of the "Major Recommendations" field.

Pressure Ulcer Prevention

Parameters of Assessment

- Perform complete skin assessment as part of the risk assessment policy and practices (European Pressure Ulcer Advisory Panel & National Pressure Ulcer Advisory Panel [EPUAP & NPUAP], 2009 [Level I]).
    - Inspect skin regularly for color changes such as redness in lightly pigmented persons and discoloration in darkly pigmented persons (EPUAP & NPUAP, 2009 [Level I])
    - Look at the skin under any medical device (e.g., catheters, oxygen, airway or ventilator tubing, face masks, braces, collars)
    - Palpate skin for changes in temperature (warmth) edema or hardness
    - Ask the patient if they have any areas of pain or discomfort over bony prominences
- Assess for intrinsic and extrinsic risk factors.
- Braden Scale risk score—18 or less for older adults and persons with darkly pigmented skin

Nursing Care Strategies and Interventions

Risk Assessment Documentation

- On admission to acute care
- Reassessment intervals whenever the client's condition changes and based on patient care setting:
  - Based on patient acuity every 24 to 48 hours in general units
  - Critically ill patients every 12 hours
- Use a reliable and standardized tool for doing a risk assessment, such as the Braden Scale as part of a comprehensive risk assessment (see *Try This* ® - issue 5: Predicting Pressure Ulcer Risk; see the "Availability of Companion Documents" field).
- Document risk assessment scores and implement prevention protocols based on overall scores, low subscores, and the comprehensive assessment of other risk factors.
- Assess risk of surgical patients for increased risk of pressure ulcers including the following factors: length of operation, number of hypotensive episodes, and/or low-core temperatures intraoperatively, reduced mobility on first day postoperatively.

General Care Issues and Interventions

- Culturally sensitive early assessment for Stage I pressure ulcers in clients with darkly pigmented skin:
  - Use a halogen light to look for skin color changes; may be purple hues or other discoloration based on patient's skin tone.
  - Compare skin over bony prominences to surrounding skin; may be boggy or stiff, warm or cooler.
- Prevention recommendations:
  - Skin care (EPUAP & NPUAP, 2009 [Level I])
    - Assess skin regularly.
    - Clean skin at time of soiling; avoid hot water and irritating cleaning agents.
    - Use emollients on dry skin.
    - Do not massage bony prominences as a pressure ulcer prevention strategy as well as do not vigorously rub skin at risk for pressure ulcers.
    - Protect skin from moisture-associated damage (e.g., urinary and/or fecal incontinence, perspiration, wound exudates) by using barrier products.
    - Use lubricants, protective dressings, and proper lifting techniques to avoid skin injury from friction and shear during transferring and turning of clients. Avoid drying out the patient's skin; use lotion after bathing.
    - Avoid hot water and soaps that are drying when bathing older adults. Use body wash and skin protectant (Hunter et al., 2003 [Level III]).
    - Teach patient, caregivers, and staff the prevention protocol.
    - Manage moisture by determining the cause; use absorbent pad that wicks moisture.
    - Protect high-risk areas such as elbows, heels, sacrum, and back of head from friction injury.
  - Repositioning and support surfaces
    - Keep patients off the reddened areas of skin.
    - Repositioning schedules should be individualized based on the patient's condition, care goals, vulnerable skin areas, and type of support surface being used (EPUAP & NPUAP, 2009 [Level I]).
    - Communicate the repositioning schedule to all the patient's caregivers.
    - Raise heels of bed-bound clients off the bed using either pillows or heel-protection devices; do not use donut-type devices (Gilcreast et al., 2005 [Level II]).
    - Use a 30 degree tilted side lying position; do not place clients directly in a 90 degree side lying position on their trochanter.
    - Keep head of the bed at lowest height possible.
    - Use transfer and lifting devices (trapeze, bed linen) to move patients rather than dragging them in bed during transfers and position changes.
    - Use pressure-reducing devices (static air, alternating air, gel, or water mattresses) (Iglesias et al., 2006 [Level II]; Hampton & Collins, 2005 [Level II]). Use higher specification foam mattresses rather than standard hospital mattresses for patients at risk for pressure ulcers. If the patient cannot be frequently repositioned manually, use an active support surface (overlay or mattress).
    - Use pressure redistributing mattresses on the operating table for patients identified at risk for developing pressure ulcers.
    - Reposition chair-bound or wheelchair-bound clients every hour. In addition, if client is capable, have him or her do small weight shifts every 15 minutes.
    - Use a pressure-reducing device (not a donut) for chair-bound clients.
    - Keep the patient as active as possible; encourage mobilization.
    - Avoid positioning the patient directly on his or her trochanter.
    - Avoid using donut-shaped devices.
    - Offer a bedpan or urinal in conjunction with turning schedules.

        - Manage friction and shear:
            - Elevate the head of the bed no more than 30 degrees.
            - Have the patient use a trapeze to lift self up in bed.
            - Staff should use a lift sheet or mechanical lifting device to move patient.
    - Nutrition
        - Assess nutritional status of patients at risk for pressure ulcers.
        - For at-risk patient, follow nutritional guidelines for hydration (1 ml/kcal of fluid per day) and calories (30 to 35 kcal/kg of body weight per day), protein (1.25 to 1.5 g/kg per day). Give high-protein supplements or tube feedings in addition to the usual diet in persons at nutritional and pressure ulcer risk (EPUAP & NPUAP, 2009 [Level I]).
        - Manage nutrition.
        - Consult a dietitian and correct nutritional deficiencies by increasing protein and calorie intake and A, C, or E vitamin supplements as needed (Centers for Medicare and Medicaid Services, 2004 [Level V]; Houwing et al., 2003 [Level II]).
        - Offer a glass of water during turning schedules to keep patient hydrated.

Interventions Linked to Braden Risk Scores (adapted from Ayello & Braden, 2001 [Level V])

Prevention protocols linked to Braden risk scores are as follows:

- At risk: score of 15 to 18
    - Frequent repositioning turning; use a written schedule.
    - Maximize patient's mobility.
    - Protect patient's heels.
    - Use a pressure-reducing support surface if patient is bed-bound or chair-bound.
- Moderate risk: score of 13 to 14
    - Same as above, but provide foam wedges for 30 degree lateral position.
- High risk: score of 10 to 12
    - Same as above, but add the following:
        - Increase the turning frequency.
        - Do small shifts of position.
- Very high risk: score of 9 or less
    - Same as above, but use a pressure-relieving surface.
    - Manage moisture, nutrition, and friction and shear.

Follow-up Monitoring of Condition

- Monitor effectiveness of prevention interventions.
- Monitor healing of any existing pressure ulcer.

Skin Tear Prevention

Parameters of Assessment

- Use the three-group risk assessment tool (White, Karam, & Cowell, 1994 [Level IV]) to assess for skin tear risk.
- Use the Payne–Martin (Payne & Martin, 1993 [Level IV]) classification system to assess clients for skin tear risk:
    - Category 1: a skin tear without tissue loss
    - Category 2: a skin tear with partial tissue loss
    - Category 3: a skin tear with complete tissue loss where the epidermal flap is absent

Nursing Care Strategies and Interventions (Baranoski, 2000 [Level V]; Baranoski & Ayello, 2008 [Level V])

Preventing Skin Tears

- Provide a safe environment:
    - Do a risk assessment of older adult patients on admission.
    - Implement prevention protocol for patients identified as at-risk for skin tears.
    - Have patients wear long sleeves or pants to protect their extremities (Bank, 2005 [Level IV]).
    - Have adequate light to reduce the risk of bumping into furniture or equipment.
    - Provide a safe area for wandering.

- Educate staff or family caregivers in the correct way of handling patients to prevent skin tears. Maintain nutrition and hydration:
  - Offer fluids between meals.
  - Use lotion, especially on dry skin on arms and legs, twice daily (Hanson et al., 1991 [Level IV]).
  - Obtain a dietary consultation.
- Protect from self-injury or injury during routine care:
  - Use a lift sheet to move and turn patients.
  - Use transfer techniques that prevent friction or shear.
  - Pad bed rails, wheelchair arms, and leg supports (Bank, 2005 [Level IV]).
  - Support dangling arms and legs with pillows or blankets.
  - Use nonadherent dressings on frail skin.
    - Apply skin protective products (creams, ointments, liquid sealants, etc.) or a nonadherent wound dressing such as hydrogel dressing with gauze as a secondary dressing, silicone, or Telfa-type dressings.
    - If you must use tape, be sure it is made of paper, and remove it gently. In addition, you can apply the tape to hydrocolloid strips placed strategically around the wound rather than taping directly onto fragile surrounding skin around the skin tear.
  - Use gauze wraps, stockinettes, flexible netting, or other wraps to secure dressings rather than tape.
  - Use no-rinse soapless bathing products (Birch & Coggins, 2003 [Level IV]; Mason, 1997 [Level IV]).
  - Keep skin from becoming dry, apply moisturizer (Bank, 2005 [Level IV]; Hanson et al., 1991 [Level IV]).

Treating Skin Tears (Baranoski & Ayello, 2008 [Level V])

- Gently clean the skin tear with normal saline.
- Let the area air dry or pat dry carefully.
- Approximate the skin tear flap.
- Use caution if using adherent dressings, as skin damage can occur when removing dressings.
- Consider putting an arrow to indicate the direction of the skin tear on the dressing to minimize any further skin injury during dressing removal.
  - Skin sealants, petroleum-based products, and other water-resistant products such as protective barrier ointments or liquid barriers may be used to protect the surrounding skin from wound drainage or dressing, or tape removal trauma.
  - Always assess the size of the skin tear; consider doing a wound tracing.
  - Document assessment and treatment findings.

Follow-up Monitoring of Condition

Continue to reassess for any new skin tears in older adults.

Definitions:

Levels of Evidence

Level I: Systematic reviews (integrative/meta-analyses/clinical practice guidelines based on systematic reviews)

Level II: Single experimental study (randomized controlled trials [RCTs])

Level III: Quasi-experimental studies

Level IV: Non-experimental studies

Level V: Care report/program evaluation/narrative literature reviews

Level VI: Opinions of respected authorities/consensus panels

AGREE Next Steps Consortium (2009). Appraisal of guidelines for research & evaluation II. Retrieved from http://www.agreetrust.org/?o=1397.

Adapted from: Melnyck, B. M. & Fineout-Overholt, E. (2005). Evidence-based practice in nursing & health care: A guide to best practice. Philadelphia, PA: Lippincott Williams & Wilkins and Stetler, C.B., Morsi, D., Rucki, S., Broughton, S., Corrigan, B., Fitzgerald, J., et al. (1998). Utilization-focused integrative reviews in a nursing service. Applied Nursing Research, 11(4) 195-206.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

- Pressure ulcers
- Skin tears

Guideline Category

Evaluation

Management

Prevention

Risk Assessment

Treatment

Clinical Specialty

Family Practice

Geriatrics

Nursing

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Hospitals

Nurses

Physician Assistants

Physicians

Guideline Objective(s)

To provide a standard of practice protocol for:

- Prevention of pressure ulcers and early recognition of pressure ulcer development and skin changes
- Prevention of skin tears in older adult clients
- Identification of clients at risk for skin tears
- Fostering healing of skin tears

Target Population

- Older adults with identified intrinsic and/or extrinsic risk factors for pressure ulcers, including:

        - Immobility as seen in bedbound or chair-bound patients and those unable to change positions
        - Undernutrition or malnutrition
        - Incontinence
        - Friable skin
        - Impaired cognitive ability
        - People with darkly pigmented skin
    - Older adults at risk for skin tears

Interventions and Practices Considered

Assessment/Evaluation/Risk Assessment

1. Complete skin assessment
2. Assessment of intrinsic and extrinsic risk factors
3. Use of the Braden Scale risk score
4. Use of the three-group risk assessment tool
5. Classification of skin tears according to the Payne-Martin system

Management/Treatment/Prevention

1. Risk assessment documentation
2. Care issues and interventions: mobilization, skin care, moisture, positioning, use of devices, nutrition, friction and shear
    - Culturally sensitive early assessment
    - Prevention recommendations
        - Skin care
        - Repositioning and support surfaces
        - Nutrition
3. Prevention protocols according to Braden risk scores
4. Prevention of skin tears
    - Safe environment
    - Education: staff or family caregivers
    - Protection from self-injury or injury during routine care
5. Treatment of skin tears

Major Outcomes Considered

- Prevalence of new pressure ulcers
- Prevalence of non-healing pressure ulcers
- Prevalence of skin tears
- Prevalence of non-healing skin tears

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Although the Appraisal of Guidelines for Research and Evaluation (AGREE) instrument (described in Chapter 1 of the original guideline document, *Evidence-based Geriatric Nursing Protocols for Best Practice*, 4th ed.) was created to critically appraise clinical practice guidelines, the process and criteria can also be applied to the development and evaluation of clinical practice protocols. Thus, the AGREE instrument has been expanded (i.e., AGREE II) for that purpose to standardize the creation and revision of the geriatric nursing practice guidelines.

The Search for Evidence Process

Locating the best evidence in the published research is dependent on framing a focused, searchable clinical question. The PICO format—an acronym for population, intervention (or occurrence or risk factor), comparison (or control), and outcome—can frame an effective literature search. The editors enlisted the assistance of the New York University Health Sciences librarian to ensure a standardized and efficient approach to collecting evidence on clinical topics. A literature search was conducted to find the best available evidence for each clinical question addressed. The results were rated for level of evidence and sent to the respective chapter author(s) to provide possible substantiation for the nursing practice protocol being developed.

In addition to rating each literature citation as to its level of evidence, each citation was given a general classification, coded as "Risks," "Assessment," "Prevention," "Management," "Evaluation/Follow-up," or "Comprehensive." The citations were organized in a searchable database for later retrieval and output to chapter authors. All authors had to review the evidence and decide on its quality and relevance for inclusion in their chapter or protocol. They had the option, of course, to reject or not use the evidence provided as a result of the search or to dispute the applied level of evidence.

Developing a Search Strategy

Development of a search strategy to capture best evidence begins with database selection and translation of search terms into the controlled vocabulary of the database, if possible. In descending order of importance, the three major databases for finding the best primary evidence for most clinical nursing questions are the Cochrane Database of Systematic Reviews, Cumulative Index to Nursing and Allied Health Literature (CINAHL), and Medline or PubMed. In addition, the PsycINFO database was used to ensure capture of relevant evidence in the psychology and behavioral sciences literature for many of the topics. Synthesis sources such as UpToDate® and British Medical Journal (BMJ) Clinical Evidence and abstract journals such as *Evidence Based Nursing* supplemented the initial searches. Searching of other specialty databases may have to be warranted depending on the clinical question.

It bears noting that the database architecture can be exploited to limit the search to articles tagged with the publication type "meta-analysis" in Medline or "systematic review" in CINAHL. Filtering by standard age groups such as "65 and over" is another standard categorical limit for narrowing for relevance. A literature search retrieves the initial citations that begin to provide evidence. Appraisal of the initial literature retrieved may lead the searcher to other cited articles, triggering new ideas for expanding or narrowing the literature search with related descriptors or terms in the article abstract.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

Level I: Systematic reviews (integrative/meta-analyses/clinical practice guidelines based on systematic reviews)

Level II: Single experimental study (randomized controlled trials [RCTs])

Level III: Quasi-experimental studies

Level IV: Non-experimental studies

Level V: Care report/program evaluation/narrative literature reviews

Level VI: Opinions of respected authorities/consensus panels

AGREE Next Steps Consortium (2009). Appraisal of guidelines for research & evaluation II. Retrieved from http://www.agreetrust.org/?o=1397 .

Adapted from: Melnyck, B. M. & Fineout-Overholt, E. (2005). Evidence-based practice in nursing & health care: A guide to best practice. Philadelphia, PA: Lippincott Williams & Wilkins and Stetler, C.B., Morsi, D., Rucki, S., Broughton, S., Corrigan, B., Fitzgerald, J., et al. (1998). Utilization-focused integrative reviews in a nursing service. Applied Nursing Research, 11(4) 195-206.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Not stated

Rating Scheme for the Strength of the Recommendations

Not applicable

Cost Analysis

The guideline developers reviewed a published cost-analysis.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

Not stated

Evidence Supporting the Recommendations

References Supporting the Recommendations

Ayello EA, Braden B. Why is pressure ulcer risk assessment so important. Nursing. 2001 Nov;31(11):74-9.

Bank D. Decreasing the incidence of skin tears in a nursingan rehabilitation center. Adv Skin Wound Care. 2005;18:74-5.

Baranoski S, Ayello EA. Wound care essentials: practice principles. Springhouse (PA): Lippincott, Williams, & Wilkins; 2008. 54-8 p.

Baranoski S. Skin tears: the enemy of frail skin. Adv Skin Wound Care. 2000;13(3):123-6.

Birch S, Coggins T. No-rinse, one-step bed bath: the effects on the occurrence of skin tears in a long-term care setting. Ostomy Wound Manage. 2003 Jan;49(1):64-7. PubMed

Centers for Medicare & Medicaid Services (CMS). Guidance for surveyors in long term care: Tag F 314: pressure ulcers. Baltimore (MD): Centers for Medicare & Medicaid Services (CMS); 2004.

European Pressure Ulcer Advisory Panel, National Pressure Ulcer Advisory Panel. Treatment of pressure ulcers: quick reference guide. Washington (DC): National Pressure Ulcer Advisory Panel; 2009.

Gilcreast DM, Warren JB, Yoder LH, Clark JJ, Wilson JA, Mays MZ. Research comparing three heel ulcer-prevention devices. J Wound Ostomy Continence Nurs. 2005 Mar-Apr;32(2):112-20. PubMed

Hampton S, Collins F. Reducing pressure ulcer incidence in a long-term setting. Br J Nurs. 2005 Aug 11-Sep 7;14(15):S6-12. PubMed

Hanson D, Langemo DK, Olson B, Hunter S, Sauvage TR, Burd C, Cathcart-Silberberg T. The prevalence and incidence of pressure ulcers in the hospice setting: analysis of two methodologies. Am J Hosp Palliat Care. 1991 Sep-Oct;8(5):18-22. PubMed

Houwing RH, Rozendaal M, Wouters-Wesseling W, Beulens JW, Buskens E, Haalboom JR. A randomised, double-blind assessment of the effect of nutritional supplementation on the prevention of pressure ulcers in hip-fracture patients. Clin Nutr. 2003 Aug;22(4):401-5. PubMed

Hunter S, Anderson J, Hanson D, Thompson P, Langemo D, Klug MG. Clinical trial of a prevention and treatment protocol for skin breakdown in two nursing homes. J Wound Ostomy Continence Nurs. 2003 Sep;30(5):250-8. PubMed

Iglesias C, Nixon J, Cranny G, Nelson EA, Hawkins K, Phillips A, Torgerson D, Mason S, Cullum N, PRESSURE Trial Group. Pressure relieving support surfaces (PRESSURE) trial: cost effectiveness analysis. BMJ. 2006 Jun 17;332(7555):1416. PubMed

Mason SR. Type of soap and the incidence of skin tears among residents of a long-term care facility. Ostomy Wound Manage. 1997 Sep;43(8):26-30. PubMed

Payne RL, Martin ML. Defining and classifying skin tears: need for a common language. Ostomy Wound Manage. 1993 Jun;39(5):16-20, 22-4, 26. PubMed

White MW, Karam S, Cowell B. Skin tears in frail elders: a practical approach to prevention. Geriatr Nurs. 1994 Mar-Apr;15(2):95-9. PubMed

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for selected recommendations (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Pressure Ulcers

Patient

- Skin will remain intact
- Healing of pressure ulcers

Provider/Nurse

- Accurate performance of pressure ulcer risk assessment using standardized tool
- Implementation of pressure ulcer prevention protocols for clients interpreted as at risk for pressure ulcers
- Performance of a skin assessment for early detection of pressure ulcers

Institution

- Reduction in development of new pressure ulcers
- Increased number of risk assessments performed
- Cost-effective prevention protocols developed

Skin Tears

- Absence of skin tears in at-risk clients
- Healing of skin tears that do occur

Potential Harms

Not stated

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Implementation Tools

Chart Documentation/Checklists/Forms

Mobile Device Resources

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Identifying Information and Availability

Bibliographic Source(s)

Ayello EA, Sibbald RG. Preventing pressure ulcers and skin tears. In: Boltz M, Capezuti E, Fulmer T, Zwicker D, editor(s). Evidence-based geriatric nursing protocols for best practice. 4th ed. New York (NY): Springer Publishing Company; 2012. p. 298-323.

Adaptation

The section on interventions linked to Braden risk scores was adapted from the following source: Ayello, E. A., & Braden, B. (2001). Why is pressure ulcer risk so important? Nursing, 31(11), 74–79.

Date Released

2003 (revised 2012)

Guideline Developer(s)

Hartford Institute for Geriatric Nursing - Academic Institution

Guideline Developer Comment

The guidelines were developed by a group of nursing experts from across the country as part of the Nurses Improving Care for Health System Elders (NICHE) project, under sponsorship of the Hartford Institute for Geriatric Nursing, New York University College of Nursing.

Source(s) of Funding

Hartford Institute for Geriatric Nursing

Guideline Committee

Not stated

Composition of Group That Authored the Guideline

Primary Authors: Elizabeth A. Ayello, PhD, RN, APRN, BC, CWOCN, FAPWCA, FAAN, President, Ayello, Harris & Associates, Inc., Clinical Associate Editor, *Advances in Skin & Wound Care*, Faculty, Excelsior College, School of Nursing, Executive Editor, *Journal of World Council of Enterostomal Therapists*; R. Gary Sibbald, MD, FRCPC, ABIM, DABD, Med Director, Wound Healing Clinic, The New Women's College Hospital and Professor, Public Health Sciences and Medicine, University of Toronto, Toronto, CA

Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Ayello EA, Sibbald RG. Preventing pressure ulcers and skin tears. In: Capezuti E, Zwicker D, Mezey M, Fulmer T, editor(s). Evidence-based geriatric nursing protocols for best practice. 3rd ed. New York (NY): Springer Publishing Company; 2008 Jan. p. 403-29.

Guideline Availability

Electronic copies: Available from the Hartford Institute for Geriatric Nursing Web site .

Copies of the book *Evidence-Based Geriatric Nursing Protocols for Best Practice*, 4th edition: Available from Springer Publishing Company, 536 Broadway, New York, NY 10012; Phone: (212) 431-4370; Fax: (212) 941-7842; Web: www.springerpub.com .

Availability of Companion Documents

The following are available:

- *Try This*® - issue 5: Predicting pressure ulcer risk. New York (NY): Hartford Institute for Geriatric Nursing; 2 p. 2012. Electronic copies: Available in Portable Document Format (PDF) from the Hartford Institute of Geriatric Nursing Web site .
- The Braden Scale. How to Try This video. Available from the Hartford Institute of Geriatric Nursing Web site .

The ConsultGeriRN app for mobile devices is available from the Hartford Institute for Geriatric Nursing Web site .

Patient Resources

None available

NGC Status

This summary was completed by ECRI on May 30, 2003. The information was verified by the guideline developer on August 25, 2003. This summary was updated on June 19, 2008. The updated information was verified by the guideline developer on August 4, 2008. This NGC summary was updated by ECRI Institute on June 25, 2013. The updated information was verified by the guideline developer on August 6, 2013.

Copyright Statement

Disclaimer

NGC Disclaimer

The National Guideline Clearinghouseâ„¢ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional

associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria.

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.